NOTRE DAME ACADEMY
EMERGENCY CONTACT FORM
2019- 2020

This form constitutes a permission statement that **must** be signed, and emergency information renewed annually through parent portal, by a parent or guardian. All of the information on this form is confidential and will be used only for the purpose of evaluating your daughter's health status and facilitating medical diagnosis, care, and/or treatment. This form will remain on file in the NDA Health Office.

Student's Name_____ Date of Birth _____/_____/_____

Last   First   M.I.

Home Address _____

City _____State _____ Zip Code _____ Current Class **20**__

EMERGENCY CONTACTS

Mother's Name _____ **Father's Name**_____

Home Phone: (_____)_____ Home Phone: (_____)_____

Work Phone: (_____)_____ Work Phone: (_____)_____

Alternate Contact _____ **Alternate Contact** _____

Home Phone: (_____)_____ Home Phone: (_____)_____

Work Phone: (_____)_____ Work Phone: (_____)_____

Student resides with: _____

PRIMARY CARE PHYSICIAN

Physician's Name: _____ Phone: (_____)_____ **Date of last physical exam**: _____/____/_____

MEDICAL INFORMATION

Allergies	Medications		
Medical Conditions/Restrictions	Contact Lenses?	Y ☐	N ☐
	Dental Appliance?	Y ☐	N ☐
Previous Concussions?	Date of Last Tetanus _____/_____/_____		

INSURANCE INFORMATION

Insurance: _____ Policy Holder: _____

ID/Policy #_____ Phone Number (____)_____

PERMISSION TO TREAT/RELEASE SUMMARY HEALTH FORM IN EMERGENCIES

I hereby give consent for the Director of Student Health Services or other health care providers considered appropriate by her to carry out accepted procedures for transport, diagnosis, immunization, medical and minor surgical treatment, or counseling for my daughter/ward. Should an emergency arise and the school authorities are unable to contact me promptly, I authorize the Principal or school official to exercise her / his best judgement in the interests of my child's welfare.

I also give permission for this Summary Health Form to be released to those Notre Dame Academy personnel or other appropriate health care providers who may need this information in order to treat my daughter/ward in a medical emergency.

Signature of Parent or Guardian_____Date: _____/_____/_____